Written comments submitted to the Department of Health Care Services (DHCS) regarding the transfer of Medi-Cal related specialty mental health functions to DHCS
Comments received July 22 through July 27, 2011

Note: In some cases, DHCS has edited the responses to explain the acronym used by the writer, or to remove personally-identifying information. Specific references to the writer's organization have not been removed.

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California Coalition for Mental Health

A Plan to meet all mental health and alcohol and drug needs by 2014.

Everything that is done over the next three years by the state and counties must be in the context of moving from the drastically underfunded current mental health and alcohol and drug programs to fully funded programs in 2014.

The quantification of that need and the financial plan for addressing will come from the Centers for Medicare and Medicaid Services (CMS) required plan as part of the 1115 waiver. That document will rely on funding from the Medicaid Expansion and insurance mandate of the national Affordable Care Act. However, it won't be enough unless several other issues are addressed as several barriers stand in the way.

Besides putting a staffing structure in place to address these barriers, DHCS needs to have a plan that identifies who and how the staff and resources will be there to address all of these barriers. For many of the issues the role of DHCS must complement the role of the Mental Health Services Oversight and Accountability Commission (MHSOAC) in its oversight of the programs funded by the Mental Health Services Act (Proposition 63 of 2004 – MHSA) and other public mental health system expenditures.

Below are lists of some of the policy areas that require specific staff, resources to obtain expertise outside of state staff and a plan to achieve policy and fiscal objectives.

1. Paperwork and Compliance – Rethink Compliance in Realigned World
2. Prevention and Early Intervention- Partnership with MHSOAC
3. Underserved Communities and Cultural Competence- Partnership with MHSOAC
4. Quality Improvement and Evaluation – Partnership with MHSOAC
5. Discrimination and Stigma – Partnership with MHSOAC
6. Decisionmaking and Relationships with mental health stakeholders - Partnership with MHSOAC
7. Workforce, Peer Support, and Recovery Model of Services
8. Co-Occurring Mental Health and Alcohol and Drug Disorders
9. Mental Health Services Act (MHSA) – Memorandum of Understanding (MOU) with MHSOAC

Detailed Preliminary Analysis of Each Program Element

1. Paperwork – Rethink Compliance in Realigned World

Community mental health providers report that 40% of their funding goes to "paperwork" (which includes everything that is not direct services). In addition counties spend an additional 15% of funds on "administration" and there are state and other administrative costs that push the non direct service costs to nearly 60% of total funding.

A national expert on efficient community mental health, David Lloyd, has worked with many states to reduce this burden through eliminating duplicative and inefficient approaches and has demonstrated that can and should get that total under 30% which for California could increase our levels of service by 50% at no cost.

Some of this is focused on providers developing ways to eliminate no shows, others on duplicative data entry and others on working with government agency and providers to develop more efficient ways to collect information and to focus on what is really worth the effort.

DMH has had a lot of its "compliance" efforts focused on ways to reduce state general fund costs of the EPSDT program while the state had to bear 90% of the non federal share of costs. With that program scheduled to be realigned to counties that motivation should disappear and there should be a plan for the state to work with counties providers and other stakeholders to minimize this paperwork burden (while retaining the data collection needed for compliance and for quality improvement as will be discussed below)

Some compliance is still required and it is envisioned that DHCS will be responsible for the performance contract (currently a DMH responsibility) to ensure that each year each county program and expenditure is in compliance with all applicable state and federal requirements. There is a need for structure for how staff will implement this requirement and ensure compliance in all expenditures – including MHSA expenditures which will be a significant part of how counties meet their MediCal obligations.

In addition there is a need for regulations not just for MediCal programs but also for MHSA programs. There is a need for staffing and a plan to prepare the regulations and update them. This must be done in partnership with the MHSOAC.

2. Prevention and Early Intervention

Mental health and alcohol and drug problems can be identified through short self questionnaires that patients or their parents complete to provide screening in primary care. Studies demonstrate the cost effectiveness of screening everyone who sees their primary care office and offering co-located modest mental health and alcohol and drug services for those whose screening reveals a need for services.

The public mental health system on its own is a "fail first" system with people not getting referred to that system until they have had a major failure in education, employment, homelessness, criminal justice or hospitalization.

These crises don't occur at the onset of a mental illness but only after the symptoms have been untreated for many years. These symptoms may be subtle and not easy for people to recognize as a sign of mental illness so people don't seek help and thus the screening questionnaires have been proven to be a necessary way to identify a mental illness early in its onset.

Primary care physicians will not do this on their own as the savings accrue mostly in hospitalizations (see County Medical Services Program [CMSP] pilot program and Lewin group study of that program which is now being expanded). However, health plans have been slow to implement these improvements as they are not always certain they will retain responsibility for patients over the longer term during which the savings accrue. Accordingly this is an area where state leadership is needed and will only happen if DHCS or the Legislature requires it of health plans and that should be part of the plan that is being developed and a policy that the

administration should embrace. Articulating this need and proposing it as part of the plan is a necessary step towards meeting all mental health and alcohol and drug needs and reducing not only higher cost mental health program caseloads but reaping even greater savings in physical health inpatient costs.

3. Underserved Communities and Cultural Competence

Latinos represent about 40% of MediCal enrollees but only about 10% of MediCal enrollees who access MediCal mental health services. Similar statistics affect most Asian cultures. Studies show that the prevalence of mental illness is about the same in all cultures and the lower utilization is the result of these cultures not seeing mental health problems as medical conditions.

Moreover, when services are delivered the services won't be successful unless delivered in a manner that addresses the culture of the client and family being served.

These two issues combined require a special focus on multicultural services for mental health that is different than for other medical conditions and an office, plans, data collection and education to address these challenges.

4. Quality Improvement and Evaluation

While the delivery of programs is the responsibility of counties, the state remains responsible to the federal government to ensure that all MediCal enrollees receive all medically necessary services in the least restrictive environment. Accordingly the state must ensure that all counties have adequate resources to meet this obligation and that they are using available resources efficiently. The performance of counties and providers must be compared to measure relative results of care and efficiency to ensure that limited resources are being used as effectively as possible and to partner with counties and providers to identify the best practices.

The MHSOAC is taking the lead in developing the evaluation tools necessary to identify best practices and educate others to improve overall quality and efficiency among providers of services. There must be a partnership between DHCS and the MHSOAC to develop the data collection, reporting and evaluation needed both for quality improvement and for compliance.
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5. Discrimination and Stigma

Mental illness is stigmatized in society with discrimination in housing, employment, education and in healthcare. If DHCS is the leading state agency in serving people enrolled in MediCal then it is responsible for the care and consequences for adults with severe mental illnesses and children with serious emotional disturbances who experience that discrimination and stigma and must support programs to address these problems and consequences. Moreover the stigma causes people to avoid seeking care for fear of the label and these delays in seeking care add to healthcare costs. There must be staff, resources and plans in partnership with counties, stakeholders and the MHSOAC to address these problems.

6. Decisionmaking and Relationships with mental health stakeholders

The mental health services act requires that the perspective of clients and families with severe mental illness must be considered in all policy and fiscal decisions. This requires a consensus oriented collaborative process in making ALL state decisions affecting these populations – nearly all of whom will be MediCal recipients by 2014. This type of process has been begun by the Department of Mental Health but has not been followed consistently. An office staffed with clients

and family members and a plan and set of regulations to ensure that such a process is consistently followed should be adopted and implemented in partnership with the MHSOAC.

7. Workforce, Peer Support, and Recovery Model of Services

As we increase mental health and alcohol and drug services there will be a need for a dramatic expansion in the number of people working in these fields and we need to have plans and programs to attract and retain the workers we need. The workforce plan must reflect the value of lived experience in the workforce meaning that a significant portion of the staffing should be individuals and families who have experienced severe mental illness. Moreover, most of the services for people with severe mental illness are recovery model services and the workforce plan must reflect the staffing needs built around the most successful programs utilizing that model as demonstrated through comparative evaluation efforts.

The MHSA includes specific funding and programs to address these issues and that plan developed by the Department of Mental Health must be updated and integrated with this DHCS division since nearly all people receiving public mental health system services will be MediCal enrollees.

8. Co-Occurring Mental Health and Alcohol and Drug Disorders

Co-Occurring Mental Health and Alcohol and Drug Disorders should be the expectation not the exception. Much of the staffing and structure of the new division of DHCS may have separate elements for mental health and alcohol and drug services. However, about half of the people who have mental illness or alcohol and drug dependence also have the other condition. Given the current and historical differences in structure, funding and services, there must be a plan for more integrated care and staff that supports the expansion of integrated care programs and policies.

9. Mental Health Services Act (MHSA)

Many parts of this paper refer to the need for partnership with the MHSOAC. Beyond those specific details is the need for state staff that is looking at how to best use those funds to achieve the primary goal of making sure that all MediCal enrollees are receiving all medically necessary services and the related goals of getting the best results from those services in the least costly and least restrictive manner feasible.

DHCS needs to have staff, resources to obtain outside experts, and a plan for how to implement the MHSA for MediCal enrollees and an MOU that delineates what DHCS is responsible for, what the MHSOAC is responsible for and what will be the responsibilities of other offices and departments.

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California Mental Health Directors Association

Short-Term Opportunities:

1. Discontinue the current DMH practice of conducting a separate annual EPSDT chart documentation audit. Instead, integrate the EPSDT audit into the existing tri-annual Medi-Cal Specialty Mental Health compliance review and chart audit.
2. Discontinue the annual External Quality Review Organization (EQRO) on-site county review. Instead, conduct tri-annual, on-site EQRO validation review to verify Mental Health Plans (MHP) compliance with federal data and performance improvement requirements. Coordinate the EQRO reviews with existing DMH compliance reviews to prevent duplication and overlap.

3. Clearly identify specific points of contact within DHCS for county consultation regarding Medi-Cal regulatory, policy and other critical county business and operational issues.
4. Review federal reimbursement processes with a focus on improving the efficiency and timeliness of interim federal certified public expenditure (CPE) payments and final settlements.
5. As they are transitioned, examine current DMH functions and priorities in light of the intent specified in Assembly Bill (AB) 102 to focus on statewide accountability and outcomes.
6. Complete the state/county MHP contract discussions and finalize the required contract.
7. Address recent significant delays in the processing of claims through Short-Doyle 2 and ensure cash flow to counties is not worsened during the transition of responsibilities to DHCS.

Mid-Term Opportunities:

1. Review and summarize the federal requirements associated with the Prepaid Inpatient Health Plan (PIHP), 1915(b) waiver and state plans to establish the "floor" for federal compliance.
2. Integrate the fiscal auditing of county MHPs into the existing DHCS audits structure for the cost report, settlement and appeals processes.
3. Reduce the redundancy in oversight and management of the Short Doyle 2 claims system between DHCS, DMH, Department of Alcohol and Drug Programs and the vendor. Perform a comprehensive review of the coding decisions made to implement the Medi-Medi and other third party claiming requirements to determine if federal requirements could be addressed more efficiently and with less coding complexity by the counties and the state.

Longer Term Opportunities:

1. In the context of Public Safety Realignment 2011, determine the basis for all non-federal Medi-Cal Specialty Mental Health administrative requirements to assure that any additional state requirements contribute to the enhancement of the Medi-Cal Specialty Mental Health system for consumers, providers and communities.

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- Stakeholders can be assisted by having a list of Department of Mental Health (DMH) employee transfer contact information – email and phone should be located on a website.

- An opportunity for stakeholders to guide DHCS to efficiencies should be provided.

- Where will Emily Q and Katie A lawsuit compliance be located?

- When will Early and Periodic Diagnosis and Treatment (EPSDT) audits restart?

- Who will be responsible for the audits – DMH or DHCS?